Claims Guidance for Community Supports (CS)

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross.

https://providers.anthem.com/ca

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Introduction

This document outlines the Anthem Blue Cross (Anthem) community supports (CS) claims and billing policy. The goals of this guide are to:

- Interpret DHCS **coding options** and **billing and invoicing** guidance.
- Provide preferred and alternate billing options.
- Facilitate and incentivize accurate and timely payments
- Collect a complete record of ECM events to inform care coordination, program improvement, and future rate setting.

Scope

This document is focused on Anthem's CalAIM CS services. CS providers that are also Enhanced Care Management (ECM) providers should refer to *Claims Guidance for Enhanced Care Management* for instructions on claims billing for ECM services.

This guidance is intended for CalAIM providers regardless of technical capacity. For providers intending to submit ANSI ASC X12N 837P or 837I claims, the document outlines data elements providers must submit, as well as file formats, transmission methods, submission timing, and adjudication processes Anthem will use to consume and process invoices.

For providers that are not intending to submit an 837, this document describes two alternative claims submission process: a provider portal process that reduces the required data elements to the minimum necessary and an invoice process compatible with DHCS **billing and invoicing** guidance. Both these alternative processes include:

- Clear instruction for submission.
- *Locked* fields to minimize submission errors, including drop-down selection options where feasible.
- Data fields which auto-populate based on previous submission (for example, service billing codes or service name).
- Automatic error checks prior to submission.

Claims submission options

Professional or institutional

There are two standards for claims submissions: *professional* and *institutional*. With the exception of the invoice process to submit your claims, you must choose one standard or the other. You indicated the standard applicable to your organization during the contracting process. Most providers have indicated *professional*. If your organization indicated *institutional*, note that guidance for this standard is still in development. Contact your Provider Experience representative to discuss interim claims submission options.

A *claim* is a request for payment by a provider to a health plan for services rendered. An *encounter* is a record of services rendered by the provider, but which is not tied directly to a payment. DHCS requires both types of records. However, Anthem recognizes that this distinction may be confusing and affect the quality or completeness of data your organization submits. To reduce the confusion, Anthem is providing a claims-only reporting option for providers.

Care Central

Care Central is Anthem's recommended process for submitting CS claims for providers that do not have an established electronic data interchange (EDI) 837 process.

Care Central is an Anthem proprietary provider portal application built within Availity,* Anthem's EDI platform, specifically for ECM and CS providers. Care Central provides an intuitive user interface, including easy claims submission functionality. Unlike other submission methods, your organization does not need a professional biller to submit claims. Anthem has developed this application so that front line staff can submit the claims. Care Central allows for a more complete and accurate data. Anthem will provide training and ongoing technical support to your staff to make this possible.

The benefits of using Care Central are:

- Simple and intuitive user interface with low administrative burden.
- Rapid turn-around-time for payment, like the Availity EDI 837 process.
- Real time claims submission receipt and claims status.
- Highest data integrity due to better accuracy and completeness of CS claims and encounter submission.

EDI 837

Availity serves as Anthem's Electronic Data Interchange (EDI) gateway. It is a one-stop shop for 837 claims submission. There is no cost to your organization to submit claims via Availity. You may submit claims to Availity directly or via a clearinghouse of your choice.

The advantages of using the EDI process are standardization, automation, and efficient claims processing.

Paper claims

Some providers may elect to submit paper claims. Please keep in mind that the paper process is the least efficient claims submission method. We expect that CS providers billing for professional services submit professional claims on a *CMS- 1500* form. Instructions for completing the *CMS-1500* can be found at **The National Uniform Claims Committee (NUCC)**.

If your organization is a hospital or other type of facility and prefer to submit institutional claims via the *UB04* form, instructions for completing this form can be found at the **National Uniform Billing Committee**. Please let us know of your billing preference at CalAIM@anthem.com.

Invoice

Anthem has created an invoice template, with the minimum number of fields necessary to successful submit a claim. This may be a backup option for provider who at a given moment are not able to access Care Central.

Table 1 Claims submission quick reference

	Specs	Process
Care Central	N/A	**1.** **Register with Availity** **2.** **Log-in** 3. Online user interface
837	**1.** **837P — Claims** **2.** **837P — Encounters** **3.** **837I — Claims** **(In Development)**	**Availity Companion Guide**

	4. **837I — Encounters (In Development)**	
Paper	Use the current standard *RED CMS Form 1500* (*02-12*) for professional claims and the *UB-04* (*CMS-1450*) for facility Claims	For additional guidance, see **Medi-Cal Provider Manual** page 128. Submit paper claims to: Claims and Billing Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007
Invoice	Excel Macro-enabled workbook To request the template, send an email to CalAIMInvoices@anthem.com.	Submit invoices to CalAIMInvoices@anthem.com via**Anthem's secure email platform**.  Secure eMail - User Guide 2018 .pdf

Claims submission policy

The CS provider is required to submit claims and encounter data for the provision of CS services to Anthem using the national standard specifications and code sets as defined by DHCS. Please see the **DHCS ECM and CS HCPCS Coding Options** for more information. This ensures that Anthem can effectively monitor the volume and frequency of CS service provision and shows the true cost of providing CS services to Anthem and DHCS. Anthem shall pay 90% of all clean claims from providers within 30 business days of date of receipt. Anthem pathways for claims submission (in order of preference) are the provider portal, EDI, and manual invoice (via secure email). Claims may be sent via secure email to CalAIMInvoices@anthem.com. Find the latest Anthem provider manuals, policies, and guidelines with additional claims guidance at **https://providers.anthem.com/ca** > Resources > **Provider Manuals, Polices and Guidelines**.

Clean claims

Please use the following guidelines when submitting a claim.

- Submit clean claims, making sure that the correct and complete information is submitted on the correct form. A clean claim is a request for payment for a service rendered by a provider that:
    - Is submitted timely.
    - Is accurate.
    - Is submitted in a *HIPAA*-compliant format or using the standard claim form including a *UB-04*, *CMS-1450* or *CMS-1500* (02-12), or successor forms thereto, or the electronic equivalent of such claim form.
    - Requires no further information, adjustment, or alteration by the provider or by a third party in order to be processed and paid by us.
- Submit claims as soon as possible after providing service.
- Submit claims within the contract filing time limit. If we do not adjudicate the clean claim within 30 business days, we will pay all applicable interest as required by law. In the event that Anthem does not finalize a clean claim within 30 business days of receipt, interest will be due to the provider if the claim is payable. Providers are notified of the disposition of a claim with either a remittance advice (RA) or a *Claims Disposition Notice* (*CDN*) when the claim is finalized.

  Paper claims that are determined to be unclean will be returned to the billing provider, along with a letter stating the reason for the rejection. Electronic claims that are determined to be

unclean will be rejected to the clearinghouse that submitted the claim. In the event you are a direct electronic submitter to Anthem, the claim will be returned to you directly.

CS (formerly ILOS) coding options

Providers must use the HCPCS codes listed in the table below to report CS services. The specified HCPCS code and modifier combinations define the service as a CS service. As an example, HCPCS code H0043 by itself does not define the service as a Housing Transition/Navigation CS service. HCPCS code H0043 must be reported with modifier U6 for the supported housing services to be defined and categorized as a CS service. If a CS service is provided through telehealth, the additional modifier GQ must be used. GQ must be noted as a secondary modifier when applicable.

CS procedure codes and modifiers

HCPCs	HCPC description/encounter unit	Modifier	Payment method
Housing Transition/Navigation Services			
H0043 **H2016**	Supported housing/Per Diem Comprehensive community support services/Per Diem	**U6** **U6**	Bundled PMPM = 1 flat rate per month for both codes
Housing Deposits			
H0044	Supported housing, per month. Requires deposit amounts to be reported on the encounter/Fixed Cost	**U2**	Actual Costs billed per claim up to lifetime max.
Housing Tenancy and Sustaining Services			
T2040 T2050 **T2041 T2051**	Financial management, self-directed/ per 15 minutes increments Support brokerage, self-directed/Per 15 minutes increments	**U6**	Bundled PMPM = 1 flat rate per month for both codes
Short-Term Post-Hospitalization Housing			
H0043 **H0044**	Supported housing/Per Month	**U3**	Per Diem
Recuperative Care (Medical Respite)			
T2033	Residential care, not otherwise specified (NOS), waiver/Per Diem	**U6**	Per Diem
Respite Services			
H0045	Respite care services, not in the home/Per Diem	**U6**	Hourly
S5151	Unskilled respite care, not hospice/Per Diem	**U6**	Hourly
S9125	Respite care, in the home/Per Diem	**U6**	Hourly

Respite Services *Anthem is in the process of updating the Respite Services codes to reflect a 15-minute increments as the payment unit. Until further notice, the payment unit remains hourly.

Day Habilitation Programs			
T2012 **T2014** **T2018** **T2020** **H2014** **H2038** **H2024** **H2026**	Habilitation, educational/Per Diem Habilitation, prevocational/Per Diem Habilitation, supported employment/ Per Diem Day habilitation/ Per Diem Skills training and development/ Per 15 minutes increments Skills training and development/ Per Diem Supported employment/ Per Diem Ongoing support to maintain employment/Per Diem	**U6**	Bundled Per diem = 1 flat rate per day for all codes
Nursing Facility Transition/Diversion to Assisted Living Facilities (RCFE)			
T2038	Community transition per service Requires billed amount(s) to be reported on the encounter/Per Service	**U4**	PMPM
H2022	Community wrap-around services Requires billed amount(s) to be reported on the encounter/Per Diem	**U5**	Per Hour
Community Transition Services/Nursing Facility Transition to a Home			
T2038	Community transition per service Requires billed amount(s) to be reported on the encounter/Per Service	**U5**	PMPM
Personal Care/Homemaker Services			
S5130	Homemaker services/Per 15 minutes increments	**U6**	15 min. increments
T1019	Personal care services/Per 15 minutes increments	**U6**	15 min. increments
Environmental Accessibility Adaptations			
S5165	Home modifications Requires billed amount(s) to be reported on the encounter/Per Service	**U6**	Actual Costs billed per claim up to lifetime max
Medically Supportive Food/Medically Tailored Meals			
S5170	Home delivered prepared meal/Per Meal **Unit Limit: 2 meals per day**	**U6**	Per Meal
S9470	Nutritional counseling, diet/Per Assessment	**U6**	Per Assessment
S9977	Meals — not otherwise specified (grocery voucher)	**U6**	Per Week
Sobering Centers			
H0014	Alcohol and/or drug services; ambulatory detoxification per diem	**U6**	Per Diem
Asthma Remediation			
S5165	Home modifications/ Per Service	**U5**	Actual Costs billed per claim up to lifetime max

Process and timelines

Table 2 Claims processing timeline

START: Provider submits claim >>	Receipt with tracking number >>	>>Compliance Edit (Availity) — Reviews to ensure that the claim complies with submission standards >>	>>Business Edit (Anthem). Review to ensure compliance with claims submission policy>>	>>Clean Claim >> Payment - END
Care Central	Instantaneous	Within 24 Hours	If a claim is unable to be processed within 10 days, Anthem will send a Remittance Advice (RA) to the Provider.	Within 30 Business Days of submitting a clean claim
837	Instantaneous	Within 24 Hours		
Paper	N/A	Paper receipt and feedback mailed within 24 of paper receipt		
Invoice	Instantaneous	Not applicable		

Data elements

Selected data elements are highlighted below. For a complete list of data elements and requirements, please refer to DHCS' **billing and invoicing** guidance.

Table 3 Data elements: Provider Information

Provider Information			
Data Elements	**Care Central**	**837/Paper**	**Invoice**
Billing Provider National Provider Identifier (NPI)	Auto-populated	Must be the organization level NPI2	
Billing Provider Tax Identification Number (TIN)	Auto-populated	This is a 10-digit identifier that must match what your organization reported to Contracting	
Billing Provider Name	Auto-populated	As recorded on your organization's *W-9* and reported to Contracting	
Rendering Provider National Provider Identifier (NPI)	N/A	Rendering provider information will be required if different than billing provider; otherwise, leave blank	

Table 4 Data elements: member information

Member Information			
Data Elements	**Care Central**	**837/Paper**	**Invoice**
Member Client Identification Number (CIN)	N/A	Member's 9-digit unique Medi-Cal identifier (for example, 9XXXXXXXA)	
Medical Record Number (MRN)	N/A		
Member Homeless Indicator	Identifier for if the Member does not have an address and is experiencing homelessness. If homeless, enter 1; if not or if unknown, leave blank.		
Member Residential Address	If homeless, enter HOMELESS.		
Member Residential City	If homeless, leave blank.		
Member Residential Zip	If homeless, leave blank.		
Member Date of Birth	N/A	(MM/DD/YYYY)	

Table 5 Data elements: Service and billing information

Service and Billing Information			
Data Elements	**Care Central**	**837/Paper**	**Invoice**
Payer Primary Identifier	N/A	47198	N/A
Payer Receiver Name	N/A	Anthem	N/A
Procedure Code(s)	*See Claims submission policy section; procedure codes and modifiers*		
Procedure Code Modifier(s)			
Service Start Date			
Service End Date			
Service Unit Count(s)	If unit = hours, minutes, units may be greater than 1 unless each occurrence (date of service) is billed on a single claim line.		
Place of Service (POS)	Suggested codes: 04 — homeless shelter 11— medical office 12 — patient home 50 — Federally Qualified Health Center 53 — Community health center 99 — other place of service not identified above		If no value entered, default to 99
Member Diagnosis Code(s)	Select the primary Dx only.	Submit at least 1 and up to 10 Dx codes per claim. Please use the Dx code with the highest level of specificity.	Select the primary Dx.If no value entered, default to Z00.0 (Other).
	Examples include, but are not limited to: Z02.9 = Administrative examinations, unspecified Z71.89 = Other specified counseling Z71.9 = Counseling, unspecified We encourage providers to use Z-codes that identify social needs. DHCS has identified the following Priority SDOH Codes (**APL 21-009**): Z55.0 Illiteracy and low-level literacy Z58.6 Inadequate drinking-water supply Z59.00 Homelessness unspecified Z59.01 Sheltered homelessness Z59.02 Unsheltered homelessness Z59.1 Inadequate housing (lack of heating/space, unsatisfactory surroundings) Z59.3 Problems related to living in residential institution Z59.41 Food insecurity Z59.48 Other specified lack of adequate food Z59.7 Insufficient social insurance and welfare support Z59.811 Housing instability, housed, with risk of homelessness Z59.812 Housing instability, housed, homelessness in past 12 months Z59.819 Housing instability, housed unspecified Z59.89 Other problems related to housing and economic circumstances Z60.2 Problems related to living alone Z60.4 Social exclusion and rejection (physical appearance, illness or behavior) Z62.819 Personal history of unspecified abuse in childhood Z63.0 Problems in relationship with spouse or partner Z63.4 Disappearance & death of family member (assumed death, bereavement)		

	Z63.5 Disruption of family by separation and divorce (marital estrangement) Z63.6 Dependent relative needing care at home Z63.72 Alcoholism and drug addiction in family Z65.1 Imprisonment and other incarceration Z65.2 Problems related to release from prison Z65.8 Other specified problems related to psychosocial circumstances (religious or spiritual problem)		
Service Charge Amounts(s)	*See Claims submission policy; CS services.*		
Taxonomy	N/A	Enter the taxonomy attached to your NPI2	N/A
Invoice Amount	N/A	N/A	Sum total of line item charges. Auto-calculated. *Charged amounts may not reflect the amount payable for the services due to payment structure and flexible rules related to submitting charges.*

Table 6 Data elements: Administrative information

Administrative Information			
Data Elements	**Care Central**	**837/Paper**	**Invoice**
Invoice Date	N/A	N/A	Auto-populates
Invoice Number	N/A	N/A	Provider-generated ten digit, numeric code that identifies the invoice being submitted.
Authorization Number	Provider must reference member's prior authorization number		

Reimbursement

The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's county of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes, and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by provider or state contract language, or by state or federal requirements or mandates. System logic or setup may prevent the loading of policies into the

claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Reimbursement hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements, or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review schedules and updates

Anthem reserves the right to review and revise its policies periodically when necessary. Reimbursement policies undergo reviews for updates to state, federal, or CMS contracts and/or requirements. Additionally, updates may be made at any time if we are notified of a mandate change or due to an Anthem business decision. When there is an update, the most current policy will be published on the website provided at the beginning of this section.

FAQ

1. **What are the rates we should be using for claims?**
   Please refer to your fully executed agreement for rates.

2. **What modifier is required?**
   Please see the CS procedure codes and modifiers section above. You may also reference the **DHCS ECM and Community Supports HCPCS Coding Options** for the list of HCPCS codes and corresponding modifiers.

3. **When using telehealth should we be adding another code?**
   If a CS service is provided through telehealth, the additional modifier GQ must be used.

4. **How do I submit claims for services rendered?**
   Your claims submission options include submission through Care Central, EDI 837, paper claim, or invoice. Please see the claims submission section above for further information about each of these options.

5. **What diagnosis code is required per CS claim?**
   CS providers should use the appropriate Z code(s) when submitting claims.

Technical questions

1. **Can I send a test file?**
   If you are sending an EDI 837 via Availity, you can code the claim as *test* or *production* in segment ISA15. Code as *test* until your validation testing is complete. For further details, see **Availity EDI Companion Guide**.

   If you are sending a claim file via a clearinghouse, you must coordinate directly with the clearinghouse.

2. **How does Anthem delimit loops and segments? Are there special characters?**
   See page three of the Anthem **837P Companion Guide**.

3. **Does the claim need a separate line for each service date or can we list the date range and a quantity?**
   Each service date must be on a separate line.

4. **Can a provider submit claims and encounters in the same report?**
   Claims and encounter cannot be sent in the same report, but they can be sent in separate reports.

   As an alternative, you may submit all events as claims. After the first claims, all claims will be paid at $0.01 and recoded as encounters before sending on to DHCS.